



Send completed forms
to DOH Communicable
Disease Epidemiology
Fax: 206-361-2930

LHJ Use ID _____
☐ **Reported to DOH** Date ____/____/____
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Other:** _____
Outbreak # (LHJ) _____ (**DOH**) _____

DOH Use ID _____
Date Received ____/____/____
DOH Classification
☐ **Confirmed**
☐ **Probable**
☐ **No count; reason:** _____

Mumps

County _____

REPORT SOURCE

Initial report date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name _____

Phone _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived Diagnosis date: ____/____/____ Illness duration: _____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ **Swollen salivary glands (parotitis)**

☐ ☐ ☐ ☐ Fever Highest measured temp: _____ °F

Type: ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ Seizures new with disease

☐ ☐ ☐ ☐ Hearing loss resulting from current illness

Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ **Parotitis**

☐ ☐ ☐ ☐ Encephalitis or encephalomyelitis

☐ ☐ ☐ ☐ Meningitis

☐ ☐ ☐ ☐ Acute pancreatitis

☐ ☐ ☐ ☐ Orchitis

☐ ☐ ☐ ☐ Mastitis

☐ ☐ ☐ ☐ Complications

Specify: _____

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Died from illness

Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy

Vaccination

Y N DK NA

☐ ☐ ☐ ☐ Vaccine up to date for current disease

Number MMR doses after first birthday: _____

Vaccine series not up to date reason:

☐ Religious exemption

☐ Medical contraindication

☐ Philosophical exemption

☐ Previous infection confirmed by laboratory

☐ Previous infection confirmed by physician

☐ Parental refusal ☐ Under age for vaccination

☐ Other: _____

☐ Unk

☐ ☐ ☐ ☐ Primary series complete for current disease

Laboratory

Collection date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ **Mumps virus isolation (clinical specimen)**

☐ ☐ ☐ ☐ **Significant rise between acute- and convalescent-phase titers in serum mumps immunoglobulin G (IgG) antibody level by any standard serologic assay**

☐ ☐ ☐ ☐ **Mumps immunoglobulin M (IgM) antibody positive serologic test**

NOTES

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:

Exposure period

-18 -15

Contagious period

1 week prior to 9 days after onset

Calendar dates:

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Destinations/Dates: _____

☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness

☐ ☐ ☐ ☐ Contact with confirmed or probable case

Y N DK NA

☐ ☐ ☐ ☐ Contact with recent foreign arrival
Specify country: _____
☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor)
☐ ☐ ☐ ☐ Congregate living
☐ Barracks ☐ Corrections ☐ Long term care
☐ Dormitory ☐ Boarding school ☐ Camp
☐ Shelter ☐ Other: _____
☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed or probable case**

☐ Patient could not be interviewed

☐ No risk factors or exposures could be identified

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Attends child care or preschool
☐ ☐ ☐ ☐ Employed in child care or preschool
☐ ☐ ☐ ☐ Do any household members work at or attend childcare or preschool
☐ ☐ ☐ ☐ Documented transmission
☐ Child care ☐ School ☐ Doctor's office
☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient ☐ Clinic ☐ Home
☐ Work ☐ College ☐ Military
☐ Correctional facility ☐ Church
☐ International travel ☐ Other: _____ ☐ Unk
☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

☐ Exclude exposed susceptibles from work/school for incubation period

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ____/____/____

Local health jurisdiction _____